STATE OF ILLINOIS
Department of Central Management Services • Bureau of Benefits

Benefit Choice Options

Enrollment Period May 1 - May 31, 2016 • Effective July 1, 2016

College Insurance Program

Benefit Choice Open Enrollment is May 1 - May 31, 2016.

Benefit Choice Form changes must be submitted to SURS no later than Tuesday, May 31st!
If you do not want to change your coverage, your current coverage will remain in place.

It is each member's responsibility to know their plan benefits and make an informed decision regarding coverage elections.

Go to the 'Latest News' section of the Benefits website at
www.benefitschoice.il.gov
for group insurance updates throughout the plan year.

Basic Insurance Terms Explained

What is an Insurance Premium?	**Insurance premiums** are the deductions taken out of your pension for your part of the insurance cost.
A **copayment** (or copay) is a fixed-dollar amount that you pay each time you have certain medical visits/procedures.	**What is a Copayment?**
What is a Deductible?	The **deductible** is the amount that you must pay toward your medical expenses before your plan will pay for any nonpreventive services.
Coinsurance is your share of the cost of a covered service, calculated as a percentage of the allowed amount for the service. You pay coinsurance after you've met your deductible.	**What is Coinsurance?**
What is an Out-of-Pocket Max (OOP)?	The **OOP** maximum is the most you will pay for eligible medical services and prescription drugs in a plan year. Once you meet your OOP max, the plan will pay 100% of eligible services. Coinsurance, copayments, and deductibles all apply toward your out-of-pocket maximum.

FY2017 Benefit Choice Period

(Enrollment Period May 1 – May 31, 2016)

The Benefit Choice Period will be **May 1 through May 31, 2016,** for all benefit recipients not enrolled in the Medicare Advantage Program. **Benefit Choice elections will be effective July 1, 2016.**

Benefit recipients or dependent beneficiaries who have never been enrolled in CIP may enroll during the Benefit Choice Period. If you are enrolling yourself or an eligible dependent for the first time during the Benefit Choice Period, please contact SURS for a CIP enrollment application.

All Benefit Choice changes should be made on the CIP Benefit Choice form. Benefit recipients should complete the form only if changes are being made. If you are already enrolled in CIP and wish to make a change in coverage, please call the State Universities Retirement System (SURS) for a Benefit Choice form at (800) 275-7877. You may also access the form when you visit the SURS website at **www.surs.org** or the Benefits website at **www.benefitschoice.il.gov**. The Benefit Choice form will only be sent upon request. SURS will process the changes based upon the information indicated on the form.

During the Benefit Choice Period, benefit recipients may:

- Change health plans.
- Add dependent coverage if never previously enrolled (adding dependent coverage requires documentation).

Attention Benefit Recipients with Medicare Parts A and B: Benefit recipients who are enrolled in Medicare Parts A and B prior to October 1, 2016, will be required to elect coverage under the CIP Medicare Advantage TRAIL Program or elect to opt out of all CIP coverage. Refer to the box on page 5 for more information regarding the Medicare Advantage TRAIL Program.

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What You Should Know for Plan Year 2017

It is each member's responsibility to know their plan benefits in order to make an informed decision regarding coverage elections. Members should carefully review all the information in this booklet to be aware of the benefit changes for the upcoming plan year. **The Benefit Choice Period will be May 1 through May 31, 2016.** All elections will be effective July 1, 2016.

- **Medicare Advantage 'TRAIL' Program:** CIP now provides coverage to eligible benefit recipients through the Medicare Advantage program. This program, referred to as the 'TRAIL' (Total Retiree Advantage Illinois), is available for benefit recipients enrolled in both Medicare Parts A and B.

  Each fall, benefit recipients who meet the criteria for enrollment in the Medicare Advantage 'TRAIL' Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. **These members will be required to choose a Medicare Advantage plan or opt out of all CIP coverage (opting out includes the termination of health, behavioral health, prescription drug, vision and dental coverage). Benefit recipients eligible for the TRAIL plans are no longer eligible for the plans offered during the Benefit Choice Period.**

  For more information regarding the Medicare Advantage 'TRAIL' Program, including eligibility criteria, go to **www.cms.illinois.gov/thetrail**.

- **Federal Healthcare Reform:** As a result of the Affordable Care Act (ACA), prescription copayments paid by members apply toward the annual out-of-pocket maximum. Once the maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year. The out-of-pocket maximum amount for each type of health plan varies and is outlined on page 14.

Be a Good Consumer - Optimize Your Benefits!

In order to get the most savings from all of your benefit plans, be sure to:

- Check with Your Doctor BEFORE having Tests/Procedures Performed. Research the provider networks of your health, prescription drug, behavioral health, dental and vision plans. All the plan administrators have contracted provider networks that can optimize your benefits and save you money. Out-of-network services can cost you considerably more money, especially fees over the plans allowable charges.
- Choose generics. If you take any medications, make sure to choose generics whenever possible. Check to see if your prescription is on the formulary list, or ask your doctor before leaving the office.

Benefit Recipient Responsibilities

You must notify SURS if:

- **You and/or your dependents experience a change of address.**
- **Your dependent loses eligibility.** Dependents that are no longer eligible under the Program (including divorced spouses or partners of a dissolved civil union) must be reported to SURS immediately. **Failure to report an ineligible dependent is considered a fraudulent act. Any premium payments you make on behalf of the ineligible dependent which result in an overpayment will not be refunded. Additionally, the ineligible dependent may lose any rights to COBRA continuation coverage.**
- **You have or gain other coverage.** If you have group coverage provided by a plan other than CIP, or if you or your dependents gain other coverage during the plan year, you must provide the other coverage plan name and effective date to SURS as soon as possible.
- **You lose other group insurance coverage.** If you or your dependents had other group coverage provided by a plan other than CIP and lose that coverage during the plan year, you must notify SURS as soon as possible to ensure coordination of benefits are processed correctly.
- **You experience a change in Medicare status.** A copy of the Medicare card must be provided to the Medicare Coordination of Benefits Unit at Central Management Services when a change in your or your dependent's Medicare status occurs. **Failure to notify the Medicare Coordination of Benefits Unit of your Medicare eligibility may result in substantial financial liabilities.** The Medicare Unit's address and phone number can be found on page 28.
- **You get married or enter into a civil union partnership; or your marriage or civil union partnership is dissolved.**
- **You have a baby or adopt a child.**
- **The employment status of your dependent changes.**
- **You have a financial or medical power of attorney (POA) who you would like to be able to make decisions and get information on your behalf if you are incapacitated.**
  - **Financial POA – used by your agent to change your health plan elections.** The financial POA document would allow an agent to make health and dental plan elections on your behalf and should be sent to your retirement system.
  - **Medical POA – used by your agent to speak with your health, dental and vision plans about your coverage and claims.** A medical POA generally gives an agent the authority to make medical decisions on your behalf; therefore, in order for your agent to speak with your health, dental and/or vision plan(s), you would need to submit the medical POA document to each plan for them to have on file.

Contact SURS if you are uncertain whether or not a life-changing event needs to be reported.

Coverage and Monthly Premiums

Benefit recipients who enroll in the College Insurance Program (CIP) receive health, prescription drug, behavioral health, dental and vision coverage. Dependent beneficiaries can be enrolled in the program at an additional cost and will have the same health plan as the benefit recipient.

As a benefit recipient enrolled in CIP, you are offered various health insurance coverage options:

- **College Choice Health Plan (CCHP)**
- **Managed Care Plans** (two types)
  - Health Maintenance Organizations (HMOs)
  - Open Access Plans (OAPs)

The health insurance options differ in the benefit levels they provide and the doctors and hospitals you can access. See the Benefits Comparison charts on pages 11-13 for information to help you determine which plan is right for you.

If you change health plans during the Benefit Choice Period, your new health insurance ID cards will be mailed to you directly from your health insurance carrier, not from the Department of Central Management Services. If you need to have services but have not yet received your ID cards, contact your health insurance carrier.

Except for benefit recipients who become enrolled in Medicare Parts A and B prior to October 1, 2016, members who select a health plan during the Benefit Choice Period will remain in that plan the entire plan year unless they experience a qualifying change in status that allows them to change plans.

Total Retiree Advantage Illinois (TRAIL)
Medicare Advantage Program

Benefit recipients who become enrolled in Medicare Parts A and B and meet all the criteria for enrollment in the Medicare Advantage Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. These members will be required to choose a Medicare Advantage plan or opt out of all CIP coverage (which includes health, behavioral health, prescription drug, dental and vision coverage) in the fall with an effective date of January 1, 2017. For more information regarding the Medicare Advantage 'TRAIL' Program, go to:

www.cms.illinois.gov/thetrail

Type of Participant	Type of Plan	Not Medicare Primary	Not Medicare Primary	Not Medicare Primary	Medicare Primary*
		Under Age 26	Age 26-64	Age 65 and Above	All Ages
Benefit Recipient	Managed Care Plan	$109.33	$273.32	$370.95	$111.19
	College Choice Health Plan	$121.99	$304.96	$431.11	$110.45
Dependent Beneficiary	Managed Care Plan	$437.31	$1,093.26	$1,483.79	$444.76
	College Choice Health Plan	$487.94	$1,219.86	$1,724.44	$441.79

* This rate applies to benefit recipients enrolled in Medicare Parts A and B, or benefit recipients enrolled in Medicare Part A only and whose Part B benefits are reduced. Send a copy of your Medicare card to SURS. If you or your dependent is actively working and eligible for Medicare, or you have additional questions about this requirement, contact the CMS Group Insurance Division, Medicare Coordination of Benefits (COB) Unit.

Federally Required Notices

Notice of Creditable Coverage

Prescription Drug Information for CIP Medicare Eligible Benefit Recipients

This Notice confirms that the College Insurance Program has determined that the prescription drug coverage it provides is creditable. This means that your existing prescription coverage is on average as good as or better than the standard Medicare prescription drug coverage (Medicare Part D). You can keep your existing group prescription coverage and choose not to enroll in a Medicare Part D plan. Unless you qualify for low-income/extra-help assistance, you should not enroll in a Medicare Part D plan.

With this Notice of Creditable Coverage, you will not be penalized if you later decide to enroll in a Medicare prescription drug plan. However, you must remember that if you drop your entire group coverage through CIP and experience a continuous period of 63 days or longer without creditable coverage, you may be penalized if you enroll in a Medicare Part D plan later. If you choose to drop your CIP coverage, the Medicare Special Enrollment Period for enrollment into a Medicare Part D plan is two months after the loss of creditable coverage.

If you keep your existing group coverage, it is not necessary to join a Medicare prescription drug plan this year. Benefit recipients who decide to enroll into a Medicare prescription drug plan; however, may need a personalized Notice of Creditable Coverage in order to enroll into a prescription plan without a financial penalty. Benefit recipients who need a personalized Notice may contact the State of Illinois Medicare Coordination of Benefits Unit at (800) 442-1300 or (217) 782-7007.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Under the Affordable Care Act, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The regulation is designed to help you better understand and evaluate your health insurance choices.

The forms include a short, plain language Summary of Benefits and Coverage (SBC) and a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for, or enrolling in, coverage or if you request a copy from your issuer or group health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan. All CIP health plan SBC's are available on the Benefits website.

Notice of Privacy Practices

The Notice of Privacy Practices have been updated on the Benefits website and were effective July 1, 2015. You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, we will post the revised Notice on our website at **www.benefitschoice.il.gov**.

Health Plan Descriptions

There are several health plans available based on geographic location. All plans offer comprehensive benefit coverage. Health maintenance organizations (HMOs) have limitations including geographic availability and defined provider networks, whereas the two open access plans (OAPs) and the College Choice Health Plan (CCHP) have nationwide networks of providers available to their members.

All health plans require a determination of medical appropriateness prior to specialized services being rendered. HMO plans require the member to obtain a copy of the authorized referral prior to services being rendered. For CCHP and OAPs, it is the member's responsibility to make sure authorization of medical services has been obtained by the health plan provider to avoid penalties or nonpayment of services. Important note: OAPs are self-referral plans. It is the member's responsibility to ensure that the provider and/or facility from which they are receiving services are either in Tier I or Tier II network to avoid significant out-of-pocket costs. For more detailed information, refer to each health plan's summary plan document (SPD).

College Choice Health Plan (CCHP)

CCHP is the medical plan that offers a comprehensive range of benefits. Under the CCHP, benefit recipients can choose any physician or hospital for medical services; however, benefit recipients receive enhanced benefits, resulting in lower out-of-pocket costs, when receiving services from a CCHP network provider. Preventive care is paid at 100 percent without having to meet the annual deductible when services are obtained through a network provider.

Benefit recipients can access plan benefit and participating CCHP network information, explanation of benefits (EOB) statements and other valuable health information online.

The CCHP has a nationwide network that consists of physicians, hospitals and ancillary providers. Notification to Cigna is required for certain medical services in order to avoid penalties. Contact Cigna at (800) 962-0051 for direction.

CCHP utilizes Magellan for behavioral health benefits and CVS/caremark for prescription benefits.

Managed Care Plans

- **Health Maintenance Organizations (HMOs)**

  Members who elect an HMO plan will need to select a primary care physician (PCP) from a network of participating providers. A PCP can be a family practice, general practice, internal medicine, pediatric or an OB/GYN physician. The PCP will direct all healthcare services and will make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, only a copayment will apply. There are no annual plan deductibles for medical services obtained through an HMO. Preventive care is paid at 100 percent when services are obtained through a network provider.

  The minimum level of HMO coverage provided by all plans is described on page 11. Please note that some HMOs provide additional coverage, over and above the minimum requirements.

  If a member is enrolled in an HMO and their PCP leaves the HMO plan's network, the member must choose another PCP within that plan. Alternatively, if CMS determines the plan's network experienced a significant change in the number of medical providers offered, the member may change health plans (the request to change health plans must be elected within 30 days of the qualifying event).

Health Plan Descriptions (cont.)

Managed Care Plans

- Open Access Plans (OAPs)

Open access plans combine similar benefits of an HMO with the same type of coverage benefits as a traditional health plan. Members who elect an OAP will have three tiers of providers from which to choose to obtain services. The benefit level is determined by the tier in which the healthcare provider is contracted. Members enrolled in an OAP can mix and match providers and tiers. Preventive care is paid at 100 percent without having to meet the annual deductible when services are obtained through a Tier I or Tier II network provider.

- Tier I offers a managed care network which provides enhanced benefits. Tier I benefits require copayments which mirror an HMO plan's copayments, but do not require a plan year deductible.
- Tier II offers another managed care network, in addition to the managed care network offered in Tier I, and also provides enhanced benefits. Tier II requires copayments, coinsurance and is subject to an annual plan year deductible.
- Tier III covers all providers which are not in the managed care networks of Tiers I or II (i.e., out-of-network providers). Using Tier III can offer members flexibility in selecting healthcare providers, but involve higher out-of-pocket costs. Tier III has a higher plan year deductible and has a higher coinsurance amount than Tier II services. In addition, certain services, such as preventive/wellness care, are not covered when obtained under Tier III. Furthermore, benefit recipients who use out-of-network providers will be responsible for any amount that is over and above the charges allowed by the plan for services, which could result in substantial out-of-pocket costs (i.e., allowable charges). When using out-of-network providers, it is recommended that the benefit recipient obtain preauthorization of benefits to ensure that medical services/stays will meet medical necessity criteria and will be eligible for benefit coverage.

Members who use providers in Tiers II and III will be responsible for the plan year deductible. **In accordance with the Affordable Care Act, these deductibles will accumulate separately from each other and will not 'cross accumulate.'** This means that amounts paid toward the deductible in one tier will not apply toward the deductible in the other tier.

Minimum level benefits are described on page 12 and may also be found in the summary plan document (SPD) on the OAP administrator's website.

Behavioral Health Services

College Choice Health Plan

Magellan Behavioral Health is the plan administrator for behavioral health services under the College Choice Health Plan (CCHP). Behavioral health services are included in an enrollee's annual medical plan year deductible and annual out-of-pocket maximum. Covered services for behavioral health which meet the plan administrator's medical necessity criteria are paid in accordance with the benefit schedule for in-network and out-of-network providers. For authorization procedures, see the Benefits Handbook or call Magellan at (800) 513-2611. Please contact Magellan for specific benefit information.

Managed Care Plans (HMO and OAP Plans)

Behavioral health services are provided under the managed care plans. Covered services for behavioral health must meet the managed care plan administrator's medical necessity criteria and will be paid in accordance with the managed care benefit schedules. Please contact the managed care plan for specific benefit information.

Important Reminders

Transition of Care after Health Plan Change: Benefit recipients who elect to change health plans and are then hospitalized prior to July 1 and are discharged on or after July 1, should contact both the current and future health plan administrators and primary care physicians as soon as possible to coordinate the transition of services.

Benefit recipients involved in an ongoing course of treatment or who have entered the third trimester of pregnancy should contact the new plan to coordinate the transition of services for treatment.

Terminating CIP Coverage: To terminate coverage at any time, notify SURS in writing. The cancellation of coverage will be effective the first of the month following receipt of the request. Benefit recipients and dependent beneficiaries who terminate from CIP may re-enroll only upon turning age 65, upon becoming eligible for Medicare or if coverage is involuntarily terminated by a former plan.

Notification of Other Group Coverage: It is the benefit recipient's responsibility to notify SURS of any addition of, or change to, other group insurance coverage during the plan year. The benefit recipient must provide their other plan information to SURS as soon as possible.

COBRA Participants: During the Benefit Choice Period, COBRA participants have the same benefit options available to them as all other benefit recipients.

Documentation Requirements: Documentation, including the SSN, is required when adding dependent coverage.

To access website links to plan administrators, visit the Benefits website at **www.benefitschoice.il.gov**.

Map of Health Plans by Illinois County

July 1, 2016 through June 30, 2017

Refer to the code key below for the health plan code for each plan by county.

BlueAdvantage HMO CI
Coventry HMO. . . . . AS
Coventry OAP . . . . . CH
Health Alliance HMO . . . AH
HealthLink OAP . . . . . CF
HMO Illinois . . . . . BY
College Choice Health Plan (CCHP) D3

AH, AS, BY, CF, CH, CI, D3

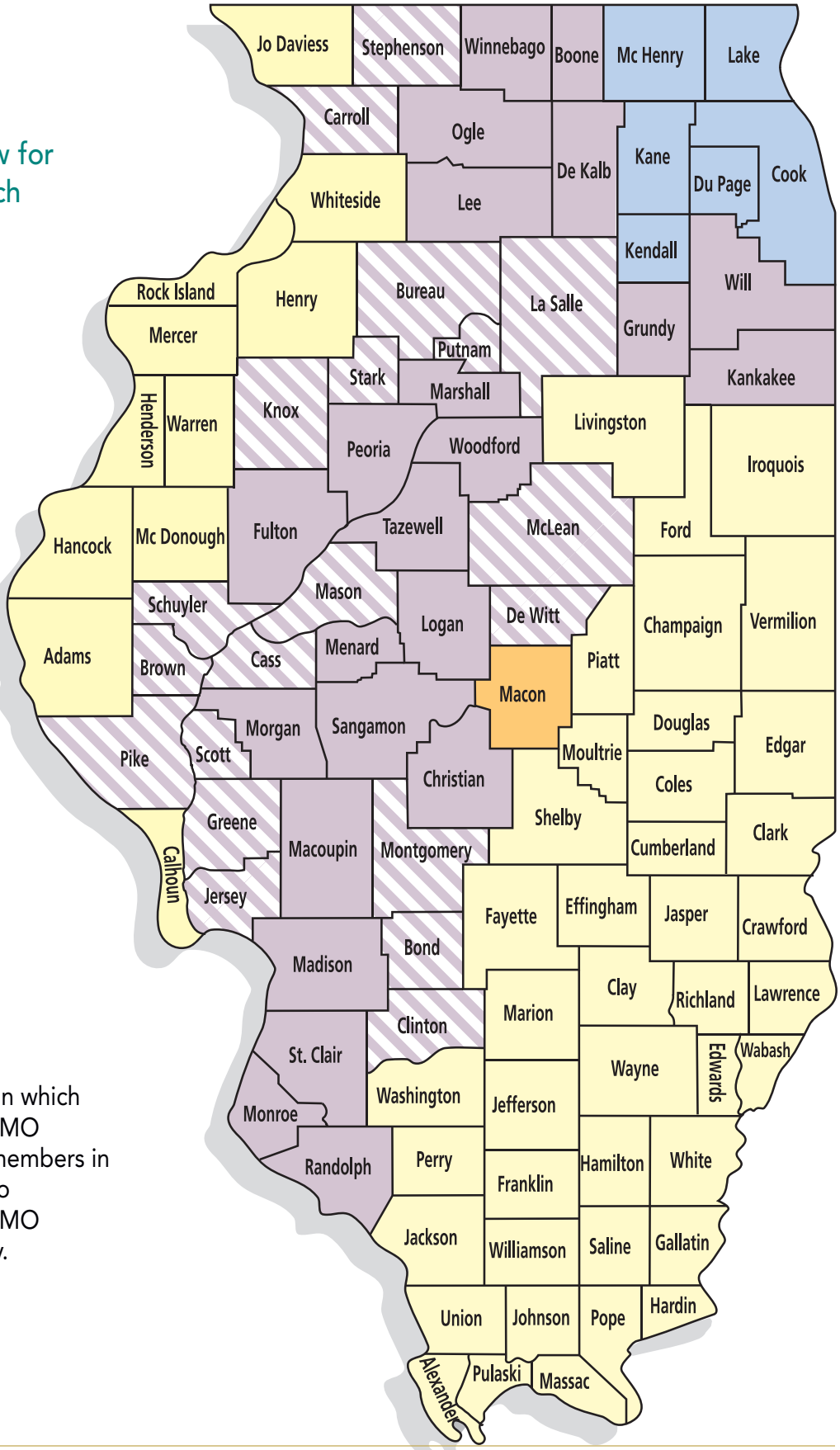
BY, CF, CH, CI, D3

AH, AS, CF, CH, D3

AH, AS, CF, CH, CI, D3

AH, AS, BY, CI, CH, CF, D3

Striped areas represent counties in which HMO Illinois or BlueAdvantage HMO do not have provider coverage; members in these counties may have access to HMO Illinois or BlueAdvantage HMO providers in a neighboring county.



HMO Benefits

Benefit recipients must select a primary care physician (PCP) from a network of participating providers. The PCP directs healthcare services and must make referrals for specialists and hospitalizations. When care and services are coordinated through the PCP, the benefit recipient pays only a copayment. No annual plan deductibles apply. The HMO coverage described below represents the minimum level of coverage an HMO is required to provide. Benefits are outlined in each plan's summary plan document (SPD). It is the benefit recipient's responsibility to know and follow the specific requirements of the HMO plan selected. Contact the plan for a copy of the SPD.

HMO Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $250 copayment per admission
Alcohol and substance abuse	100% after $250 copayment per admission
Psychiatric admission	100% after $250 copayment per admission
Outpatient surgery	100% after $200 copayment
Diagnostic lab and x-ray	100%
Emergency room hospital services	100% after $200 copayment per visit
Professional and Other Services (Copayment not required for preventive services)	
Physician Office visit	100% after $30 copayment per visit
Preventive Services, including immunizations	100%
Specialist Office visit	100% after $30 copayment per visit
Well Baby Care (first year of life)	100%
Outpatient Psychiatric and Substance Abuse	100% after $30 copayment per visit
Prescription drugs (30-day supply) (formulary is subject to change during plan year)	$12 copayment for generic $24 copayment for preferred brand $48 copayment for nonpreferred brand $96 copayment for specialty
Durable Medical Equipment	80%
Home Health Care	100% after $30 copayment per visit

Some HMOs may have benefit limitations based on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD.

Benefit	Tier I 100% Benefit	Tier II 80% Benefit	Tier III (Out-of-Network) 60% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Max Per Individual Enrollee Per Family	$6,600 (includes eligible charges from Tier I and Tier II combined) $13,200 (includes eligible charges from Tier I and Tier II combined)		Not Applicable
Annual Plan Deductible (must be satisfied for all services)	$0	$300 per enrollee*	$400 per enrollee*
Hospital Services			
Inpatient	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Inpatient Psychiatric	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Inpatient Alcohol and Substance Abuse	100% after $250 copayment per admission	80% of network charges after $300 copayment per admission	60% of allowable charges after $400 copayment per admission
Emergency Room	100% after $200 copayment per visit	100% after $200 copayment per visit	100% after $200 copayment per visit
Outpatient Surgery	100% after $200 copayment per visit	80% of network charges after $200 copayment	60% of allowable charges after $200 copayment
Diagnostic Lab and X-ray	100%	80% of network charges	60% of allowable charges
Physician and Other Professional Services (Copayment not required for preventive services)			
Physician Office Visits	100% after $30 copayment	80% of network charges	60% of allowable charges
Specialist Office Visits	100% after $30 copayment	80% of network charges	60% of allowable charges
Preventive Services, including immunizations	100%	100%	Covered under Tier I and Tier II only
Well Baby Care (first year of life)	100%	100%	Covered under Tier I and Tier II only
Outpatient Psychiatric and Substance Abuse	100% after $30 copayment	80% of network charges	60% of allowable charges
Other Services			
Prescription Drugs (30-day supply) Generic $12 Preferred Brand $24 Nonpreferred Brand $48 Specialty $96			
Durable Medical Equipment	80% of network charges	80% of network charges	60% of allowable charges
Skilled Nursing Facility	100%	80% of network charges	Covered under Tier I and Tier II only
Transplant Coverage	100%	80% of network charges	Covered under Tier I and Tier II only
Home Health Care	100% after $30 copayment	80% of network charges	Covered under Tier I and Tier II only

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year basis.

The College Choice Health Plan (CCHP)

Plan Year Maximums and Deductibles	
Plan Year Maximum Lifetime Maximum	Unlimited Unlimited
Plan Year Deductible	$750 per benefit recipient
Additional Deductibles* * These are in addition to the plan year deductible.	Each emergency room visit $400 CCHP hospital admission $250 Non-CCHP hospital admission $500 Transplant deductible $250

Out-of-Pocket Maximum Limits			
In-Network Individual $1,500	In-Network Family $3,000	Out-of-Network Individual $4,500	Out-of-Network Family $9,000

Hospital Services	
CCHP Hospital Network	$250 deductible per hospital admission. 80% after annual plan deductible.
Non-CCHP Hospitals	$500 deductible per hospital admission. 60% of allowable charges after annual plan deductible.

Outpatient Services	
Preventive Services, including immunizations	100% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Diagnostic Lab/X-ray	80% in-network, 60% of allowable charges out-of-network, after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	
Licensed Ambulatory Surgical Treatment Centers	

Professional and Other Services	
Services included in the CCHP Network	80% after the annual plan deductible.
Services not included in the CCHP Network	60% of allowable charges after the annual plan deductible.
Chiropractic Services – medical necessity required (up to a maximum of 30 visits per plan year)	80% in-network, 60% of allowable charges after the annual plan deductible.

Transplant Services	
Organ and Tissue Transplants	80% after $250 transplant deductible, limited to network transplant facilities as determined by the medical plan administrator. Benefits are not available unless approved by the Notification Administrator, Cigna. To assure coverage, the transplant candidate must contact Cigna prior to beginning evaluation services.

Prescription Drugs	
Prescription Drugs (30-day supply)	Generic $12.50 Preferred Brand $25.00 Nonpreferred Brand $50.00 Specialty $100.00

Out-of-Pocket Maximum

After the out-of-pocket maximum has been satisfied, the plan will pay 100 percent of covered expenses for the remainder of the plan year. Charges that apply toward the out-of-pocket maximum for each type of plan varies and are outlined in the chart below.

In accordance with the Affordable Care Act (ACA), prescription copayments paid by members will also apply toward the out-of-pocket maximum; therefore, once the out-of-pocket maximum has been met, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

The following are the types of charges that apply to the out-of-pocket maximum by plan type:

- **College Choice Health Plan:**
  - Annual medical plan year deductible
  - Prescription copayments
  - Medical coinsurance
  - CCHP additional medical deductibles

Eligible charges for in-network and out-of-network services will accumulate separately and will not cross accumulate.

- **HMO Plans:**
  - Medical and prescription copayments
  - Medical coinsurance

- **OAP Plans (only applies to Tier I and Tier II providers):**
  - Annual medical plan year deductible (Tier II)
  - Medical and prescription copayments
  - Medical coinsurance

Eligible charges from Tiers I and II will be added together when calculating the out-of-pocket maximum. Tier III does not have an out-of-pocket maximum.

Certain charges are always the member's responsibility and do not count toward the out-of-pocket maximum, nor are they covered after the out-of-pocket maximum has been met. Charges that do not count toward the out-of-pocket maximum include:

- The dispense as written (DAW) penalty (i.e., the cost difference between a brand medication and a generic medication, plus the brand copayment, when a generic medication is available);
- Amounts over allowable charges for the plan;
- Noncovered services;
- Charges for services deemed to be not medically necessary; and
- Penalties for failing to precertify/provide notification.

CHARGES THAT APPLY TOWARD OUT-OF-POCKET MAXIMUM

PLAN	Out-of-Pocket Maximum Limits	Annual Plan Year Deductible	Additional Deductibles (CCHP)/ Copayments	Medical Coinsurance	Pharmacy Copayments	Amounts over Allowable Charges (CCHP out-of-network providers and OAP Tier III providers)
CCHP	**In-Network** Individual $1,500 Family $3,000	X	X	X	X	**Amounts over the plan's allowable charges are the member's responsibility and do not go toward the out-of-pocket maximum.**
	Out-of-Network Individual $4,500 Family $9,000	X	X	X	X	
HMO	Individual $3,000 Family $6,000	N/A	X	X	X	
OAP Tier I	Individual $6,600 Family $13,200 Tier I and Tier II charges combined	N/A	X	X	X	
OAP Tier II		X	X	X	X	
OAP Tier III	N/A	N/A	N/A	N/A	N/A	

Note: Eligible charges for medical, behavioral health and prescription drugs that the member pays toward the plan year deductibles, as well as plan copayments and/or coinsurance will be added together for the out-of-pocket maximum calculation. OAP Tier III does not have an out-of-pocket maximum.

Benefit Recipients (and Dependents) Eligible for Medicare

What is Medicare?

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has the following parts to help cover specific services:

Medicare Part A

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home Health care

Part A coverage is premium-free for benefit recipients with enough earned credits based on their own work history or that of a spouse at least 62 years of age (when applicable) as determined by the Social Security Administration (SSA).

Medicare Part B

- Services from doctors and other health care providers
- Outpatient care
- Durable medical equipment
- Some preventative services

Part B coverage requires a monthly premium contribution. With limited exception, enrollment is required for benefit recipients who are retired or who have lost "current employment status" and are eligible for Medicare.

Medicare Part C

- Includes all benefits and services covered under Part A and Part B
- Usually includes Medicare prescription drug coverage (Part D) as part of the plan
- Run by Medicare-approved private insurance companies
- May include extra benefits and services

Part C coverage (known as Medicare Advantage) requires a monthly premium contribution. The State of Illinois offers a CIP-sponsored Medicare Advantage plan option that includes Part D coverage to eligible benefit recipients (see the box on page 16 titled **Total Retiree Advantage Illinois (TRAIL)**) for more information.

Medicare Part D

- Helps cover the cost of prescription drugs
- Run by Medicare-approved private insurance companies

Medicare Part D coverage requires a monthly premium contribution, unless the benefit recipient qualifies for extra-help assistance as determined by the SSA.

In order to apply for Medicare benefits, plan participants are instructed to contact their local SSA office or call (800) 772-1213. Benefit recipients may also contact the SSA via the internet at **www.socialsecurity.gov**

College Insurance Program Medicare Requirements

Each benefit recipient must contact the SSA and apply for Medicare benefits upon turning the age of 65. If the SSA determines that a benefit recipient is eligible for Medicare Part A at a premium-free rate, **CIP requires** that the benefit recipient accept the Medicare Part A coverage.

If the SSA determines that a benefit recipient is not eligible for premium-free Medicare Part A based on his/her own work history or the work history of a spouse at least 62 years of age (when applicable), the benefit recipient must request a written statement of the Medicare ineligibility from the SSA. Upon receipt, the written statement must be forwarded to the State of Illinois Medicare COB Unit to avoid a financial penalty. Benefit recipients who are ineligible for premium-free Medicare Part A benefits, as determined by the SSA, are not required to enroll into Medicare.

Benefit Recipients Eligible for Medicare (cont.)

To ensure that healthcare benefits are coordinated appropriately and to prevent financial liabilities with healthcare claims, benefit recipients must notify the State of Illinois when they become eligible for Medicare and submit a copy of the Medicare identification card to the State of Illinois Medicare COB Unit. The Medicare COB Unit can be reached by calling (800) 442-1300 or (217) 782-7007.

Medicare Part B

Benefit recipients eligible for premium-free Medicare Part A are required to enroll in Medicare Part B. In most cases, Medicare is the primary payer for health insurance claims over the College Insurance Program. Failure to enroll and maintain enrollment in Medicare Part B when Medicare is determined to be the primary insurance payer will result in a reduction of benefits for healthcare claims.

Benefit recipients who terminate Medicare Part A and or B coverage must notify the State of Illinois Medicare COB Unit immediately and provide the date the Medicare coverage ended.

Benefit Recipients Eligible for Medicare on the Basis of End-Stage Renal Disease (ESRD)

Benefit recipients of any age who are eligible for Medicare benefits based on End-Stage Renal Disease (ESRD) must contact the State of Illinois Medicare COB Unit for information regarding Medicare requirements and to ensure proper calculation of the 30-month coordination of benefit period.

Benefit Recipients with Additional Insurance

Benefit recipients who are actively working (or retired) with additional insurance through that employment must submit a copy of their insurance identification card along with the effective date of the other plan's coverage to the State of Illinois Medicare COB Unit in order to ensure the proper coordination of benefits for healthcare claims.

Benefit recipients can contact the State of Illinois Medicare COB Unit via phone at (800) 442-1300 or (217) 782-7007.

Total Retiree Advantage Illinois (TRAIL)
Medicare Advantage Program

Benefit recipients (as well as their covered dependents) who become enrolled in Medicare Parts A and B and meet all the criteria for enrollment in the Medicare Advantage Program will be notified of the TRAIL Open Enrollment Period by the Department of Central Management Services. These members will be required to choose a Medicare Advantage plan or opt out of all CIP coverage (opting out includes the termination of health, behavioral health, prescription drug and vision coverage) in the fall with an effective date of January 1, 2017. For more information regarding the Medicare Advantage 'TRAIL' Program, go to:

www.cms.illinois.gov/thetrail

Prescription Benefit

Benefit recipients enrolled in any CIP health plan have prescription drug benefits included in the coverage. Benefit recipients who have additional prescription drug coverage, including Medicare, should contact their plan's prescription benefit manager (PBM) for coordination of benefits (COB) information. Please note that when a pharmacy dispenses a brand drug for any reason and a generic is available, the benefit recipient must pay the cost difference between the brand product and the generic product, plus the brand copayment. This is known as the dispense as written (DAW) penalty.

The maximum fill that CCHP and OAP benefit recipients can obtain at a retail pharmacy is 60 days worth of medication; however, benefit recipients can obtain a 90-day supply of medication through the mail order pharmacy. A 90-day supply through the mail order pharmacy will cost two copayments instead of three. The maximum fill that an HMO benefit recipient can obtain at a retail pharmacy varies by health plan. Contact your health plan for more information.

To compare formulary lists, cost-savings programs and to obtain a list of pharmacies that participate in the various health plan networks, benefit recipients should visit the website of each health plan they are considering.

Specialty Drug Category

A specialty drug is a medication that typically costs $500 or more per dose or $6,000 or more per year and has one or more of the following characteristics:

- Is a complex therapy for a complex disease;
- Is used for specialized patient training and coordination of care (services, supplies or devices) and is required prior to therapy initiation and/or during therapy;
- Has unique patient compliance and safety monitoring requirements;
- Has unique requirements for handling, shipping and storage; or
- Has a potential for significant waste.

Formulary Lists: All prescription medications are compiled on a preferred formulary list (i.e., drug list) maintained by each health plan's prescription benefit manager (PBM). Formulary lists categorize drugs in three levels: generic, preferred brand and nonpreferred. Each category has a different copayment amount. Coverage for specific prescription drugs may vary depending upon the health plan. **Formulary lists are subject to change any time during the plan year.** Therefore, when a prescribed medication the benefit recipient is currently taking is reclassified into a different formulary list category or is excluded either the health plan or the PBM will notify benefit recipients by mail. If a formulary change occurs, benefit recipients should consult with their physician to determine if a change in prescription is appropriate.

CVS/caremark: (877) 232-8128
TDD/TTY: (800) 231-4403
Website: www.caremark.com

Vision Plan

Vision coverage is provided at no additional cost to benefit recipients enrolled in any of the CIP health plans. All benefit recipients and enrolled dependents have the same vision coverage regardless of the health plan selected. All vision benefits are available once every 24 months from the last date used. Copayments are required.

Service	Network Provider Benefit	Out-of-Network Provider Benefit**
Eye Exam	$10 copayment	$20 allowance
Spectacle Lenses* (single, bifocal and trifocal)	$10 copayment	$20 allowance for single vision lenses $30 allowance for bifocal and trifocal lenses
Standard Frames	$10 copayment (up to $90 retail frame cost; member responsible for balance over $90)	$20 allowance
Contact Lenses (All contact lenses are in lieu of spectacle lenses)	$20 copayment for medically necessary $50 copayment for elective contact lenses $70 allowance for all other lenses not mentioned above	$70 allowance

* Spectacle Lenses: Benefit recipient pays any and all optional lens enhancement charges. Network providers may offer additional discounts on lens enhancements and multiple pair purchases.
** Out-of-network claims must be filed within one year from the date of service.

EyeMed Vision Care: (866) 723-0512
TDD/TTY: (800) 526-0844
Website: www.eyemedvisioncare.com/stil

Dental Plan

All benefit recipients and enrolled dependents have the same dental benefits available regardless of the health plan selected.

Dental Benefit

The College Choice Dental Plan (CCDP) is a dental plan that offers a comprehensive range of benefits administered by Delta Dental of Illinois. The CCDP reimburses only those services listed on the Dental Schedule of Benefits (available on the Benefits website). Listed services are reimbursed at a predetermined maximum scheduled amount. Each benefit recipient is subject to an annual plan deductible for all dental services, except those listed in the Schedule of Benefits as 'Diagnostic' or 'Preventive'. The annual plan deductible is $100 per participant per plan year. Once the deductible has been met, the benefit recipient has a maximum annual dental benefit of $2,000 for all dental services.

Benefit recipients enrolled in the dental plan can choose any dental provider for services; however, benefit recipients may pay less out-of-pocket when they receive services from a network dentist. There are two separate networks of dentists that a benefit recipient may utilize for dental services in addition to out-of-network providers: the Delta Dental PPOSM network and the Delta Dental PremierSM network.

- **Delta Dental PPO℠ Network** If you receive services from a PPO-level dentist you can maximize your dental benefits and minimize your out-of-pocket expenses because these providers accept a lower negotiated PPO fee (less any deductible). If the PPO fee is lower than the amount listed on the Schedule of Benefits, the PPO dentist cannot bill you for the difference.

Deductible and Plan Year Maximum

Annual Deductible for Preventive Services	N/A
Annual Deductible for All Other Covered Services	$100
Plan Year Maximum Benefit*	$2,000

- **Delta Dental Premier℠ Network** If you receive services from a Premier-level dentist, your out-of-pocket expenses may also be less because Premier providers accept the allowed Premier-level fee (less any deductible). If the allowed fee is lower than the amount listed on the Schedule of Benefits, the Premier dentist cannot bill you for the difference.
- **Out-of-Network** If you receive services from a dentist who does not participate in either the PPO or Premier network, you will receive benefits as provided by the Schedule of Benefits. You will likely pay more than you would if you went to a Delta Dental network dentist. Out-of-network dentists will charge you for the difference between their submitted fee and the amount listed on the Schedule of Benefits.

Benefit recipients can access CCDP network information, explanation of benefits (EOB) statements and other valuable information online by registering with Delta Dental of Illinois Member Connection.

It is strongly recommended that benefit recipients obtain a pretreatment estimate for any service over $200, regardless of whether that service is to be received from an in-network or an out-of-network provider. Failure to obtain a pretreatment estimate may result in unanticipated out-of-pocket costs. A pretreatment estimate is a review by Delta Dental of a dental provider's proposed treatment, including diagnostic, x-ray and laboratory reports, as well as the expected charges. This treatment plan is sent to Delta Dental for verification of eligible benefits. Obtaining a pretreatment estimate to verify coverage will help you make decisions regarding your dental services and help you avoid unanticipated out-of-pocket costs. Questions regarding a pretreatment estimate can be addressed by Delta Dental.

* Orthodontics + all other covered services = Plan Year Maximum Benefit

Dental Plan (cont.)

Provider Payment

If you use a Delta Dental network dentist, you will not have to pay the dentist at the time of service (with the exception of applicable deductibles, charges for noncovered services, charges over the amount listed on the Schedule of Benefits and/or amounts over the annual maximum benefit).

Network dentists will automatically file the dental claim for their patients. Out-of-network dentists can elect to accept assignment from the plan or may require other payment terms. Benefit recipients who use an out-of-network dentist may have to pay the entire bill at the time of service and/or file their own claim form depending on the payment arrangements the benefit recipient has with their dentist.

Example of PPO, Premier and Out-of-Network Dentist Payments (this is a hypothetical example only and assumes the deductible has been met).

Delta Dental PPO Dentist*		Delta Dental Premier Dentist*		Out-of-Network Dentist	
Dentist submitted fee	$1,000	Dentist submitted fee	$1,000	Dentist submitted fee	$1,000
PPO maximum allowed fee	$790	Premier maximum allowed fee	$900	No negotiated fee	n/a
Schedule of Benefits amount	$781	Schedule of Benefits amount	$781	Schedule of Benefits amount	$781
Your Out-of-Pocket Cost	$9	Your Out-of-Pocket Cost	$119	Your Out-of-Pocket Cost	$219

* When utilizing a PPO or Premier dentist, if the maximum allowed fee is greater than the amount listed on the Schedule of Benefits, the network dentist can bill the member the difference between the two amounts.

Child Orthodontia Benefit

The child orthodontia benefit is available only to children who begin treatment prior to the age of 19. The maximum lifetime benefit for child orthodontia is $1,500. This lifetime maximum is based on the length of treatment (see 'Length of Orthodontia Treatment' chart below). This lifetime maximum applies to each benefit recipient regardless of the number of courses of treatment. **Note:** The annual plan year deductible must be satisfied each plan year that the benefit recipient is receiving orthodontia treatment unless it was previously satisfied for other dental services incurred during the plan year.

Length of Orthodontia Treatment	Maximum Benefit
0 - 36 Months	$1,500
0 - 18 Months	$1,364
0 - 12 Months	$780

Prosthodontic Limitations

(Prosthodontics include full dentures, partial dentures, implants and crowns)

- Prosthodontics to replace missing teeth are covered only for teeth that are lost while the benefit recipient is covered by CCDP.
- Multiple procedures are subject to limitations. Please refer to the Dental Schedule of Benefits PRIOR to the start of any procedure to clarify coverage limitations.

Delta Dental: (800) 323-1743
TDD/TTY: (800) 526-0844
Website: http://soi.deltadentalil.com

Wellness Offerings

Be Well, Get Well, Stay Well

CIP offers many valuable wellness programs to help keep our members healthy and help unhealthy members get healthier. The goal is for all members to lead better, more satisfying lives.

Our Wellness Program

CIP is highlighting its current wellness program to provide even more assistance to you. The program focuses on improving lifestyle choices, including eating healthier, being more physically active, ending tobacco use, managing stress more effectively, and getting more sleep. The goal is to help you avoid chronic health problems (or help stabilize/improve them, if applicable), such as diabetes, heart disease, high blood pressure and high cholesterol.

What You Can Do Now

Steps you can take to be healthier and live better:

- Step 1: Get a checkup. It is vitally important to have a preventive health exam each year, including (as applicable based on your age and gender) a Pap smear, prostate exam, mammogram, colonoscopy, cancer screening and immunizations. Your health plan covers many preventive services at no cost to you, as required under Federal Health Care Reform laws.
- Step 2: Take advantage of your medical plan's resources. Many CIP-offered medical plans have valuable wellness resources such as health information libraries, online health coaching, dedicated nurse phone lines and wellness publications. Visit your plan's website to find out what's available to you.
- Step 3: Know your numbers, know your risks. A smart step to getting healthier and staying that way, is to…
  - …Know your numbers: Get biometric screenings from your doctor. These are simple and quick tests that measure your blood pressure, pulse rate, blood glucose (sugar), total cholesterol, body mass index (BMI), height and weight. You can get them when you go for an annual physical.
  - …Take a Health Risk Assessment (HRA): Complete a private, confidential HRA on your medical plan's website. It asks basic health-related questions like, "Did you get a flu shot?" and "Do you wear a seat belt?" There are no right or wrong answers. The information you provide—and HRA results—is not shared with CIP. You'll get instant results after you complete an HRA, including a personal action plan. (Using your biometric screening information will give you the most accurate results.) Share your results and action plan with your doctor. Discuss with your physician ways you can maintain good health or improve your health.

Disease Management Programs

Disease Management Programs are utilized by the health plans as a way to improve the health of benefit recipients. Members and dependents identified with certain risk factors indicating diabetes, cardiac health and many other chronic health conditions will be contacted by the medical plans to participate in these programs. These **highly confidential programs** are based upon certain medical criteria and provide:

- Healthcare support available 24-hours-a-day, 7-days-a-week with access to a team of registered nurses (RNs) and other qualified health clinicians;
- Wellness tools, such as reminders of regular health screenings;
- Educational materials pertaining to your health condition, including identification of anticipated symptoms and ways to better manage these conditions;
- Valuable information and access to discounted services from weight-loss programs.

Quick Reference Guide for Preventive Health Coverage

Under the Affordable Care Act, you and your family are eligible for some important preventive services which can help you avoid illness and improve your health at no additional cost to you.

What This Means for You

The Affordable Care Act, the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010, helps make prevention affordable and accessible for all Americans by requiring health plans to cover preventive services at 100 percent and eliminating cost sharing for those services. Preventive services that have strong scientific evidence of their health benefits must be covered and plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by a network provider. If you are eligible for a preventive service due to age or medical history, you may have access to preventive services at no cost such as:

- Blood pressure, diabetes and cholesterol tests.
- Many cancer screenings, including mammograms and colonoscopies.
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use.
- Routine vaccinations against diseases such as measles, polio or meningitis.
- Flu and pneumonia shots.
- Counseling, screening and vaccines to ensure healthy pregnancies.
- Regular well-baby and well-child visits, from birth to age 21.

Some Important Details

Things to know about preventive care and services:

- **Network providers:** If your health plan uses a network of providers, be aware that health plans are required to provide these preventive services at no charge to you when an in-network provider is used. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
- **Office visit fees:** Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay all or a portion of costs of the office visit if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.
- **Talk to your healthcare provider:** To know which covered preventive services are right for you, based on your age, gender and health status, ask your healthcare provider.
- **Questions:** If you have questions about whether these new provisions apply to your plan, contact your plan administrator.

This document does not guarantee coverage for all preventive services. Specific terms of coverage, exclusions and limitations are included in the plan administrator's summary plan document.

Wellness Exams & Immunizations

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)	● ● ●	• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2–4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21, once a year • Ages 22 and older, periodic visits, as doctor advises

The following routine immunizations are currently designated preventive services

SERVICE	SERVICE
Diphtheria, Tetanus Toxoid and acellular pertussis (DTaP, Tdap, Td)	Meningococcal (MCV)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (Hep A)	Poliovirus (IPV)
Hepatitis B (Hep B)	Rotavirus (RV)
Human papillomavirus (HPV) (age and gender criteria apply depending on vaccine brand)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Alcohol misuse screening	● ● ●	All adults; adolescents at risk
Anemia screening	●	Pregnant women
Aspirin to prevent cardiovascular disease[1]	● ●	Men ages 45–79; women ages 55–79
Autism screening	●	18, 24 months
Bacteriuria screening	●	Pregnant women
Breast cancer screening (mammogram)	●	Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies[2]	●	During pregnancy and after birth
Cervical cancer screening (Pap test) HPV DNA test with Pap test	●	Women ages 21–65, every 3 years Women ages 30–65, every 5 years
Chlamydia screening	●	Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening	● ● ●	• Screening of children and adolescents ages 9-11 years and 18-21 years; children and adolescents with risk factors ages 2-8 and 12-16 years • All men ages 35 and older, or ages 20–35 if risk factors • All women ages 45 and older, or ages 20–45 if risk factors
Colon cancer screening	● ●	The following tests will be covered for colorectal cancer screening, ages 50 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires precertification

● = Men ● = Women ● = Children/adolescents

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening	🟢	Newborns
Critical congenital heart disease screening	🟢	Newborns before discharge from hospital
Contraception counseling/education. Contraceptive products and services[1,3,4]	🟣	Women with reproductive capacity
Depression screening	🔵🟣🟢	Ages 11–21, All adults
Developmental screening	🟢	Newborn 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Diabetes screening	🔵🟣	Adults with sustained blood pressure greater than 135/80
Discussion about potential benefits/risk of breast cancer preventive medication[1]	🟣	Women at risk
Dental caries prevention (evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1])	🟢	Children older than 6 months
Domestic and interpersonal violence screening	🟣	All women
Fall prevention in older adults (physical therapy, vitamin D supplementation[1])	🔵🟣	Community-dwelling adults ages 65 and older with risk factors
Folic acid supplementation[1]	🟣	Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing	🟣	Women at risk • Genetic counseling must be provided by an independent board-certified genetic specialist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening	🟣	Pregnant women
Gonorrhea screening	🟣	Sexually active women age 24 years and younger and older women at risk
Hearing screening (not complete hearing examination)	🟢	All newborns by 1 month. Ages 4, 5, 6, 8, and 10 or as doctor advises
Healthy diet and physical activity counseling	🔵🟣🟢	Ages 6 and older - to promote improvement in weight status. Overweight or obese adults with risk factors for cardiovascular disease
Hemoglobin or hematocrit	🟢	12 months
Hepatitis B screening	🟣	Pregnant women
Hepatitis C screening	🔵🟣	Adults at risk; one-time screening for adults born between 1945 and 1965
HIV screening and counseling	🔵🟣🟢	Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women, annually
Iron supplementation[1]	🟢	6–12 months for children at risk
Lead screening	🟢	12, 24 months
Lung cancer screening (low-dose computed tomography)	🔵🟣	Adults ages 55 to 80 with 30 pack-year smoking history, and currently smoke, or have quit within the past 15 years.
Metabolic/hemoglobinopathies (according to state law)	🟢	Newborns
Obesity screening/counseling	🔵🟣🟢	Ages 6 and older, all adults
Oral health evaluation/assess for dental referral	🟢	12, 18, 24, 30 months. Ages 3 and 6

🔵 = Men 🟣 = Women 🟢 = Children/adolescents

Health Screenings & Interventions

SERVICE	GROUP	AGE, FREQUENCY
Osteoporosis screening	●	Age 65 or older (or under age 65 for women with fracture risk as determined by Fracture Risk Assessment Score).
PKU screening	●	Newborns
Ocular (eye) medication to prevent blindness	●	Newborns
Prostate cancer screening (PSA)	●	Men ages 50 and older or age 40 with risk factors
Rh incompatibility test	●	Pregnant women
Sexually transmitted infections (STI) counseling	● ● ●	Sexually active women, annually; sexually active adolescents; and men at increased risk
Sexually transmitted infections (STI) screening	●	All sexually active adolescents.
Sickle cell disease screening	●	Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation	● ● ●	Ages 10–24
Syphilis screening	● ● ●	Individuals at risk; pregnant women
Tobacco use/cessation interventions	● ●	All adults; pregnant women
Tobacco use prevention (counseling to prevent initiation)	●	School-age children and adolescents
Tuberculin test	●	Children and adolescents at risk
Ultrasound aortic abdominal aneurysm screening	●	Men ages 65–75 who have ever smoked
Vision screening (not complete eye examination)	●	Ages 3, 4, 5, 6, 8, 10, 12, 15 and 18 or as doctor advises

● = Men ● = Women ● = Children/adolescents

Other coverage: Your plan supplements the preventive care services listed above with additional services that are commonly ordered by primary care physicians during preventive care visits. These include services such as urinalysis, EKG, thyroid screening, electrolyte panel, Vitamin D measurement, bilirubin, iron and metabolic panels.

1. Subject to the terms of your plan's pharmacy coverage, certain drugs and products may be covered at 100%. Your doctor is required to give you a prescription, including for those that are available over-the-counter, for them to be covered under your pharmacy benefit. Cost sharing may be applied for brand-name products where generic alternatives are available.
2. Subject to the terms of your plan's medical coverage, breast-feeding equipment rental and supplies may be covered at the preventive level.
3. Examples include oral contraceptives; diaphragms; hormonal injections and contraceptive supplies (spermicide, female condoms); emergency contraception.
4. Subject to the terms of your plan's medical coverage, contraceptive products and services such as some types of IUD's, implants and sterilization procedures may be covered at the preventive level. Check your plan materials for details about your specific medical plan.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and, with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Exclusions

This document provides highlights of preventive care coverage generally. Some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the specific coverage terms of your plan, refer to your plan's summary pan document.

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Plan Administrators

Who to contact for information

Health Plan Administrators	Toll-Free Telephone Number	TDD/TTY Number	Website Address
BlueAdvantage HMO	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois
College Choice Health Plan (Cigna)	(800) 962-0051	(800) 526-0844	www.cigna.com/stateofil
Coventry Health Care HMO	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Coventry Health Care OAP	(800) 431-1211	(217) 366-5551	www.chcillinois.com
Health Alliance HMO	(800) 851-3379	(800) 526-0844	www.healthalliance.org/stateofillinois
HealthLink OAP	(800) 624-2356	(800) 624-2356 ext. 6280	www.healthlink.com/illinois_index.asp
HMO Illinois	(800) 868-9520	(866) 876-2194	www.bcbsil.com/stateofillinois

Plan Component	Administrator's Name and Address	Customer Service Phone Numbers	Website Address
Vision Plan	EyeMed Out-of-Network Claims P.O. Box 8504 Mason, OH 45040-7111	(866) 723-0512 (800) 526-0844 (TDD/TTY)	www.eyemedvisioncare.com/stil
College Choice Dental Plan (CCDP) Administrator	Delta Dental of Illinois Group Number 20240 P.O. Box 5402 Lisle, IL 60532	(800) 323-1743 (800) 526-0844 (TDD/TTY)	http://soi.deltadentalil.com
Health/Dental Plans, Medicare COB Unit, and Smoking Cessation Benefit	CMS Group Insurance Division 801 South 7th Street P.O. Box 19208 Springfield, IL 62794-9208	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)	www.benefitschoice.il.gov
General Eligibility and Enrollment Information	State Universities Retirement System (SURS) 1901 Fox Drive P.O. Box 2710 Champaign, IL 61825-2710	(800) 275-7877 (800) 526-0844 (TDD/TTY)	www.surs.org

Plan Administrators

Who to contact for information

Plan Component	Contact For	Administrator's Name and Address	Customer Service Contact Information
College Choice Health Plan (CCHP) Medical Plan Administrator	Medical service information, network providers, claim forms, ID cards, claim filing/resolution and predetermination of benefits	Cigna Group Number 2457490 Cigna HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) www.cigna.com/stateofil
CCHP Notification and Medical Case Management Administrator	Notification prior to hospital services Noncompliance penalty of $400 applies	Cigna CCHP Group #2457490	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY)
Prescription Drug Plan Administrator CCHP (1399CD3) Coventry OAP (1399CCH) HealthLink OAP (1399CCF)	Information on prescription drug coverage, pharmacy network, mail order, specialty pharmacy, ID cards and claim filing	CVS/caremark Group Number: 1399CD3 1399CCH, 1399CCF Paper Claims: CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Mail Order Prescriptions: CVS/caremark P.O. Box 94467 Palatine, IL 60094-4467	(877) 232-8128 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
CCHP Behavioral Health Administrator	Notification, authorization, claim forms and claim filing/resolution for behavioral health services	Magellan Behavioral Health CCHP Group #2457490 P.O. Box 2216 Maryland Heights, MO 63043	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanHealth.com

DISCLAIMER

The State of Illinois intends that the terms of this plan are legally enforceable and that the plan is maintained for the exclusive benefit of Members. The State reserves the right to change any of the benefits, program requirements and contributions described in this Benefit Choice Options Booklet. This Booklet is intended to supplement the Benefits Handbook. If there is a discrepancy between the Benefit Choice Options Booklet, the Benefits Handbook and state or federal law, the law will control.

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